

CONDITIONS OF PARTICIPATION; EXTENDED CARE FACILITIES



FEDERAL HEALTH INSURANCE FOR THE AGED

(CODE OF FEDERAL REGULATIONS,
TITLE 20, CHAPTER III, PART 405)

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U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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PREFACE

Regulations relating to the Health Insurance for the Aged program are published in the Federal Register and Code of Federal Regulations under Title 20 -- Employees' Benefits, Chapter III -- Social Security Administration, Department of Health, Education, and Welfare. The Code of Federal Regulations and the Federal Register issues may be purchased from the Superintendent of Documents, Government Printing Office.

This Health Insurance Regulations (HIR-11) document sets forth Subpart K of the Social Security Administration's Regulations No. 5 (Federal Health Insurance for the Aged -- Part 405) titled, Conditions of Participation; Extended Care Facilities. Appropriate provisions of the regulations may be cited or shown to the public in reply to questions about the authority for taking a particular action or position in certain matters.

CHECK SHEET FOR HEALTH INSURANCE REGULATIONS REVISION TRANSMITTALS

This Check Sheet should be used to provide a record of revisions received.

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This edition is a reprint of the regulations with all existing revisions incorporated. No other changes have been made. It is not intended as a replacement for manuals which have been currently maintained and are in usable condition but is for distribution where additional copies are required.

SUBPART K

CONDITIONS OF PARTICIPATION; EXTENDED CARE FACILITIES

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SUBPART K

Conditions of Participation; Extended Care Facilities

NOTE: §§ 405.1101 to 405.1137 issued under sections 1102, 1861(j), 1864, and 1871, 49 Stat. 647, as amended, 79 Stat. 317, 79 Stat. 326, 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

405.1101 General.—(a) In order to participate as an extended care facility in the health insurance program for the aged, an institution must be an “extended care facility” within the meaning of section 1861 (j) of the Social Security Act. This section of the law states a number of specific requirements which must be met by participating extended care facilities and authorizes the Secretary of Health, Education, and Welfare to prescribe other requirements considered necessary in the interest of health and safety of beneficiaries.

SEC. 1861. For purposes of this title—

* * * * *

(j) The term “extended care facility” means (except for purposes of subsection (a) (2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(10) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863);

except that such term shall not (other than for purposes of subsection (a) (2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a) (2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term “extended care facility” also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

(b) The requirements included in the statute and the additional health and safety requirements prescribed by the Secretary are set forth in the Conditions of Participation for Extended Care Facilities. An institution which meets all of the specific statutory requirements and which is found to be in substantial compliance with the additional conditions prescribed by the Secretary may, if it so desires, agree to become a participating extended care facility.

(c) The Secretary may, at the request of a State, approve higher health and safety requirements for that State. Also, where a State or political subdivision imposes higher requirements on institutions as a condition for the purchase of services under a State plan approved under title I, XVI, or XIX of the Social Security Act, the Secretary is required to impose like requirements as a condition to the payment for services in such institutions in that State or subdivision.

(d) (1) The extended care benefit provided by the health insurance program for the aged is intended to be a benefit for those persons who, though they no longer require the level of intensive care

ordinarily furnished in a general hospital, continue to need for medical reasons a level of care entailing medically supervised skilled nursing and related services on a continuing basis in an institutional setting. The extended care benefit covers not only postacute hospitalization where the individual is convalescing or being rehabilitated but also those types of cases where the patient may continue to be severely ill and indeed have little or no prospect of recovery. (The physician's certification required by section 1814(a)(2)(D) of the Social Security Act is, in part, that the extended care facility services are required because the patient needs "skilled nursing care on a continuing basis" for any of the conditions for which he had just been previously hospitalized. Thus, a terminal cancer patient who may receive only palliative treatment but whose condition requires skilled nursing services available at all times would qualify for extended care benefits.) The underlying program purpose of the extended care benefit is to encourage the most effective and economical utilization of available medical care resources and facilities. Since it will be necessary for many aged patients who are hospitalized for intensive treatment of an acute phase of illness to undergo a period of medically supervised convalescence or care in a facility which is staffed and equipped to provide skilled nursing and other restorative services, the extended care benefit was provided to enable physicians to transfer patients (when the physician determines the transfer is medically appropriate), to such facilities rather than allowing patients to continue unnecessarily to occupy high-cost hospital beds.

(2) Accordingly, an extended care facility, whether it is a distinct part of an institution or a separate institution, is a facility which provides a level of care distinguishable from the level of intensive care ordinarily furnished by a general hospital. This level of care is reflected in the conditions of participation. While the conditions call for a wide range of specialized medical services and the employment by the facility in adequate numbers of a variety of paramedical and skilled nursing personnel, the emphasis is on the provision of skilled nursing and related care rather than the type of care and treatment required in the acute phase of an illness. Similarly, although the legislative language concerning rehabilitation services is the same with respect to hospitals and extended care facilities, the general concept of an extended care facility is that of an intermediate institution which provides post-hospital, subacute services. Hence, a rehabilitation hospital would be equipped and staffed to diagnose and evaluate the patient's disability and to

initiate a rehabilitation regime. A rehabilitation extended care facility, on the other hand, would be staffed and equipped to continue and modify such a regime during the patient's convalescence.

(3) Thus, neither the title used by an institution, nor the statute under which it is licensed, necessarily identifies its function as being that of either a hospital or an extended care facility in the context of title XVIII. Its primary purpose and the way it carries out its program of services must be evaluated and determined. In the final analysis, the hospital is designed to initiate care, including diagnosis and treatment. The extended care facility is designed to continue care, with appropriate modifications as the patient's condition changes.

(e) Attention is invited to the requirements of Title VI of the Civil Rights Act of 1964 (78 Stat. 252; P.L. 88-352) which provides that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance (sec. 601), and to the implementing regulation issued by the Secretary of Health, Education, and Welfare with the approval of the President (Part 80 of this title).

405.1102 Conditions of Participation; General.—For an institution to be eligible for participation in the program, it must meet the statutory requirements of section 1861(j) and there must be a finding of substantial compliance on the part of the institution with all the other conditions. These conditions which include both the statutory requirements and the additional health and safety requirements prescribed by the Secretary are set forth in §§ 405.1120 through 405.1137. They are requirements relating to the quality of care and the adequacy of the services and facilities which the institution provides. Variations in the type and size of the institutions and the nature and scope of services offered will be reflected in differences in the details of organization, staffing, and facilities. However, the test is whether there is substantial compliance with the prescribed conditions of participation.

405.1103 Standards; General.—As a basis for a determination as to whether or not there is substantial compliance with the prescribed conditions in the case of any particular extended care facility, a series of standards, almost all interpreted by explanatory factors, are listed under each con-

dition. These standards represent a broad range and variety of activities which such facilities may undertake or be pursuing in order to carry out the functions embodied in the conditions. Reference to these standards will enable the State agency surveying a facility to document the activities of the institution, to establish the nature and extent of its deficiencies, if any, with respect to any particular function, and to assess the facility's need for improvement in relation to the prescribed conditions. In substance, the application of the standards, together with the explanatory factors, will indicate the extent and degree to which an extended care facility is complying with each condition.

405.1104 Certification by State Agency.—

(a) The Health Insurance for the Aged Act provides that the services of State agencies, operating under agreements with the Secretary, will be used by the Secretary in determining whether institutions meet the conditions of participation. Pursuant to these agreements, State agencies will certify to the Secretary, extended care facilities which, are found to be in substantial compliance with the conditions. Such certifications shall include findings as to whether each of the conditions is substantially met. The Secretary, on the basis of such certification from the State agency, will determine whether or not an institution is an extended care facility eligible to participate in the health insurance program as a provider of services.

(b) The decisions of the State agency represent recommendations to the Secretary. Notice of determination of eligibility or noneligibility made by the Secretary on the basis of a State agency decision will be sent to the institution concerned by the Social Security Administration after such review and professional consultation with the Public Health Service as may be required. If it is determined that the institution does not comply with the conditions of participation, the institution may request that the determination be reviewed. For procedures relating to the appeals process, see Subpart O of this Part 405.

(Par. (b) amended 12-18-68.)

405.1105 Principles for the Evaluation of Extended Care Facilities to Determine Whether They Meet the Conditions of Participation.—Extended care facilities will be considered in substantial compliance with the conditions of participation upon acceptance by the Secretary of findings, adequately documented and certified to by the State agency, showing that:

(a) The facility meets the specific statutory re-

quirements of section 1861(j) and is found to be operating in accordance with all other conditions of participation with no significant deficiencies, or

(b) The facility meets the specific statutory requirements of section 1861(j) but is found to have deficiencies with respect to one or more other conditions of participation which:

(1) It is making reasonable plans and efforts to correct, and

(2) Notwithstanding the deficiencies, is rendering adequate care and is without hazard to the health and safety of individuals being served, taking into account special procedures or precautionary measures which have been or are being instituted.

405.1106 Time Limitations on Certifications of Substantial Compliance.—

(a) All initial certifications by the State agency to the effect that an extended care facility is in substantial compliance with the conditions of participation will be for a period of 1 year, beginning with January 1, 1967, or if later, with the date on which the facility is first found to be in substantial compliance with the conditions. State agencies may visit or resurvey institutions where necessary to ascertain continued compliance or to accommodate to periodic or cyclical survey programs. A State finding and certification to the Secretary that an institution is no longer in compliance may occur within a 1-year or subsequent period of certification and will thereby terminate the State certification as to compliance.

(b) If an extended care facility is in substantial compliance under the provisions of § 405.1105(b), the following information will be incorporated in the Secretary's finding and into the notice of eligibility to the facility:

(1) A statement of the deficiencies which were found, and

(2) A description of progress which has been made and further action which is being taken to remove the deficiencies, and

(3) A scheduled time for a resurvey of the institution to be conducted not later than the ninth month (or earlier, depending on the nature of the deficiencies) of the period of certification.

(Par. (b) amended 12-18-68.)

405.1107 Certification of Noncompliance.

—(a) The State agency will certify that an institution is not in compliance with the conditions of participation or, where a determination of eligibility has been made, that an institution is no longer in compliance where:

(1) The institution is not in compliance with one or more of the statutory requirements of section 1861(j), or

(2) The institution has deficiencies of such character as to seriously limit the capacity of the institution to render adequate care or to place health and safety of individuals in jeopardy, and consultation to the institution has demonstrated that there is no early prospect of such significant improvement as to establish substantial compliance as of a later beginning date, or

(3) After a previous period or part thereof for which the institution was certified under circumstances outlined in § 405.1105(b), there is a lack of progress toward a removal of deficiencies which the State agency finds are adverse to the health and safety of individuals being served.

(b) If, on the basis of a State agency certification, it is determined by the Secretary that the institution does not substantially meet, or no longer substantially meets, the conditions of participation, an agreement for participation may not be accepted for filing, or if filed, may be terminated. The institution may request that the determination be reviewed. For procedures relating to the appeals process, see Subpart O of this Part 405.

(Section heading and par. (b) amended 12-18-68.)

405.1108 Criteria for Determining Substantial Compliance.—Findings made by a State agency as to whether an extended care facility is in substantial compliance with the conditions of participation require a thorough evaluation of the degree to which operation of a facility demonstrates adequate performance of the functions which are embodied in the conditions. The State evaluation will take into consideration:

(a) The degree to which each standard, as well as the total set of standards relating to a condition of participation, is met;

(b) When there is a deficiency in meeting a standard, whether the deficiency is one concerning the statutory requirements which must be met by all extended care facilities (sec. 1861(j));

(c) Whether the deficiency creates a hazard to health and safety; and

(d) Whether the facility is making reasonable plans and efforts to correct the deficiency within a reasonable period.

405.1109 Documentation of Findings.—The findings of the State agency with respect to each of the conditions of participation should be adequately documented. Where the State agency cer-

tification to the Secretary is that an institution is not in compliance with the conditions of participation, such documentation should include a report of all consultation which has been undertaken in an effort to assist the institution to comply with the conditions, a report of the institution's responses with respect to the consultation, and the State agency's assessment of the prospects for such improvements as to enable the institution to achieve substantial compliance with the conditions.

405.1110 Authorization for Special Certification.—(a) Where, because of the absence of any participating extended care facility or hospital in an area, the denial of eligibility of an institution to participate in the program would result in beneficiaries not having access to needed services, an institution may, upon recommendation by the State agency, be approved by the Secretary as an extended care facility. Such approval will be granted only where there are no deficiencies of such character and seriousness as to place health and safety of individuals in jeopardy. An institution receiving this special approval shall furnish information showing the extent to which it is making the best use of its resources to improve its quality of care. Resurveys of such institutions will be made at least semiannually.

(b) Each case will have to be decided on its individual merits; and while the degree and extent of compliance will vary, the institution must, as a minimum, meet all of the statutory conditions in section 1861(j)(1)–(9), in addition to meeting such other requirements as the Secretary finds necessary under section 1861(j)(10).

405.1129 Condition of Participation—Compliance With State and Local Laws.—The extended care facility is in conformity with all applicable Federal, State, and local laws, regulations and similar requirements.

(a) *Standard; Licensing of Institution.*—In any State in which State or applicable local law provides for the licensing of extended care facilities, the institution (1) is licensed pursuant to such law, or (2) is approved by the agency of the State or locality responsible for licensing such institutions, as meeting the standards established for such licensing.

(b) *Standard; Licensing of Staff.*—Staff of the extended care facility is currently licensed or registered in accordance with applicable laws.

(c) *Standard; Conformity With Laws.*—The extended care facility is in conformity with laws relating to fire and safety, communicable and reportable diseases, and other relevant matters.

405.1121 Condition of Participation—Administrative Management.—The extended care facility has an effective governing body legally responsible for the conduct of the facility, which designates an administrator and establishes administrative policies. However, if the extended care facility does not have an organized governing body, the persons legally responsible for the conduct of the extended care facility carry out or have carried out the functions herein pertaining to the governing body.

(a) *Standard; Governing Body.*—There is a governing body which assumes full legal responsibility for the overall conduct of the facility. The factors explaining the standard are as follows:

(1) The ownership of the facility is fully disclosed to the State agency. In the case of corporations, the corporate officers are made known.

(2) The governing body is responsible for compliance with the applicable laws and regulations of legally authorized agencies.

(b) *Standards; Full-Time Administrator.*—The governing body appoints a full-time administrator who is qualified by training and experience and delegates to him the internal operation of the facility in accordance with established policies. The factors explaining the standard are as follows:

(1) The administrator is at least 21 years old, capable of making mature judgments, and has no physical or mental disabilities or personality disturbances which interfere with carrying out his responsibilities.

(2) It is desirable for the administrator to have a minimum of a high school education, to have completed courses in administration or management and to have had at least 1 year of work experience including some administrative experience in an extended care facility or related health program.

(3) The administrator's responsibilities for procurement and direction of competent personnel are clearly defined.

(4) An individual competent and authorized to act in the absence of the administrator is designated.

(5) The administrator may be a member of the governing body.

(c) *Standard; Personnel Policies.*—There are written personnel policies, practices, and procedures that adequately support sound patient care. The factors explaining the standard are as follows:

(1) Current employee records are maintained and include a résumé of each employee's training and experience.

(2) Files contain evidence of adequate health supervision such as results of preemployment and periodic physical examination, including chest X-rays, and records of all illnesses and accidents occurring on duty.

(3) Work assignments are consistent with qualifications.

(d) *Standard; Notification of Changes in Patient Status.*—There are appropriate written policies and procedures relating to notification of responsible persons in the event of significant change in patient status, patient charges, billings, and other related administrative matters. The factors explaining the standard are as follows:

(1) Patients are not transferred or discharged without prior notification of next of kin or sponsor.

(2) Information describing the care and services provided by the facility is accurate and not misleading.

405.1122 Condition of Participation—Patient Care Policies.—There are policies to govern the skilled nursing care and related medical or other services provided, which are developed with the advice of professional personnel, including one or more physicians and one or more registered professional nurses. A physician, a registered professional nurse, or a medical staff is responsible for the execution of these policies.

(a) *Standard; Policies Regarding Nursing and Medical Care.*—(1) The extended care facility has written policies which are developed with the advice of (and with provision for review of such policy from time to time by) a group of professional personnel, including at least one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides. Policies reflect awareness of and provision for meeting the total needs of patients. These are reviewed at least annually and cover at least the following:

(i) Admission, transfer, and discharge policies including categories of patients accepted and not accepted by extended care facility.

(ii) Physician services.

(iii) Nursing services.

(iv) Dietary services.

(v) Restorative services.

(vi) Pharmaceutical services.

- (vii) Diagnostic services.
 - (viii) Care of patients in an emergency, during a communicable disease episode, and when critically ill or mentally disturbed.
 - (ix) Dental services.
 - (x) Social services.
 - (xi) Patient activities.
 - (xii) Clinical records.
 - (xiii) Transfer agreement.
 - (xiv) Utilization review.
- (2) The factors explaining the standard are as follows:

(i) It is desirable that the group of professional personnel responsible for patient care policies includes health personnel such as social workers, dietitians, pharmacists, speech pathologists and audiologists, physical and occupational therapists, and mental health personnel. Pharmacy policies and procedures are preferably developed with the advice of a subgroup of physicians and pharmacists, serving as a pharmacy and therapeutics committee.

(ii) Some members of this group are neither owners nor employees of the facility.

(iii) The group meets at regularly scheduled intervals and minutes of each meeting are recorded.

(iv) The group may serve one or more facilities.

(b) Standard; Responsibilities; Execution of Patient Care Policies.—The extended care facility has a physician, a registered professional nurse, or a medical staff responsible for the execution of patient care policies established by the professional group referred to in paragraph (a)(1) of this section. The factors explaining the standard are as follows:

(1) If the organized medical staff is responsible, an individual physician is designated to maintain compliance with overall patient care policies.

(2) If a registered professional nurse is responsible, the facility makes available an advisory physician from whom she receives medical guidance.

405.1123 Condition of Participation—Physician Services.—Patients in need of skilled nursing care are admitted only upon the recommendation of a physician; their health care continues under the supervision of a physician; and the facility has a physician available to furnish necessary medical care in case of emergency.

(a) Standard; Medical Findings and Physicians' Orders.—There is made available to the facility,

prior to or at the time of admission, patient information which includes current medical findings, diagnoses, rehabilitation potential, a summary of the course of treatment followed in the hospital, and orders from a physician for the immediate care of the patient. The factors explaining the standard are as follows:

(1) If the above information is not available in the facility upon admission of the patient, it is obtained by the facility within 48 hours after admission.

(2) If medical orders for the immediate care of a patient are unobtainable at the time of admission, the physician with responsibility for emergency care gives temporary orders.

(3) A current hospital discharge summary contains the above information is acceptable.

(b) Standards; Supervision by Physician.—The facility has a requirement that the health care of every patient is under the supervision of a physician who, based on an evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of medical care which covers indicated medications, treatments, restorative services, diet, special procedures recommended for the health and safety of the patient, activities, plans for continuing care and discharge. The factors explaining the standard are as follows:

(1) The medical evaluation of the patient is based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days prior to admission.

(2) The charge nurse and other appropriate personnel involved in the care of the patient assist in planning his total program of care.

(3) The patient's total program of care is reviewed and revised at intervals appropriate to his needs. Attention is given to special needs of patients such as foot, sight, speech, and hearing problems.

(4) Orders concerning medications and treatments are in effect for the specified number of days indicated by the physician but in no case exceed a period of 30 days unless recorded in writing by the physician.

(5) Telephone orders are accepted only when necessary and only by licensed nurses. Telephone orders are written into the appropriate clinical record by the nurse receiving them and are countersigned by the physician within 48 hours.

(6) Patients are seen by a physician at least once every 30 days. There is evidence in the clinical record of the physician's visits to the patient at appropriate intervals.

(7) There is evidence in the clinical record that the physician has made arrangements for the medical care of the patient in the physician's absence.

(8) To the extent feasible, each patient or his sponsor designates a personal physician.

(c) *Standard; Availability of Physicians for Emergency Care.*—The extended care facility provides for having one or more physicians available to furnish necessary medical care in case of emergency if the physician responsible for the care of the patient is not immediately available. A schedule listing the names and telephone numbers of these physicians and the specific days each is on call is posted in each nursing station. There are established procedures to be followed in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.

405.1124 Condition of Participation—Nursing Services.—The extended care facility provides 24-hour nursing service which is sufficient to meet the nursing needs of all patients. There is at least one registered professional nurse employed full time and responsible for the total nursing service. There is a registered professional nurse or licensed practical nurse who is a graduate of a State approved school of practical nursing in charge of nursing activities during each tour of duty. The terms "licensed practical nurse(s)" and "practical nursing" as used in this section are synonymous with "licensed vocational nurse(s)" and "vocational nursing."

(a) *Standard; Full-Time Nurse.*—There is at least one registered professional nurse employed full time. If there is only one registered professional nurse, she serves as director of the nursing service, works full time during the day, and devotes full time to the nursing service of the facility. If the director of nursing has administrative responsibility for the facility, she has a professional nurse assistant so that there is the equivalent of a full-time director of nursing service. The director of nursing service is trained or experienced in areas such as nursing service administration, rehabilitation nursing, psychiatric or geriatric nursing.

(b) *Standard; Director of Nursing Service.*—The director of the nursing service is responsible for:

(1) Developing and/or maintaining nursing service objectives, standards of nursing practice, nursing procedure manuals, and written job descriptions for each level of nursing personnel;

(2) Recommending to the administrator the

number and levels of nursing personnel to be employed, participating in their recruitment and selection, and recommending termination of employment when necessary;

(3) Assigning and supervising all levels of nursing personnel;

(4) Participating in planning and budgeting for nursing care;

(5) Participating in the development and implementation of patient care policies and bringing patient care problems requiring changes in policy to the attention of the professional policy advisory groups;

(6) Coordinating nursing services with other patient care services such as physician, physical therapy, occupational therapy, and dietary;

(7) Planning and conducting orientation programs for new nursing personnel, and continuing inservice education for all nursing personnel;

(8) Participating in the selection of prospective patients in terms of nursing services they need and nursing competencies available;

(9) Assuring that a nursing care plan is established for each patient and that his plan is reviewed and modified as necessary.

(c) *Standard; Supervising Nurse.*—Nursing care is provided by or under the supervision of a full-time registered professional nurse currently licensed to practice in the State. The factors explaining the standard are as follows:

(1) The supervising nurse is trained or experienced in areas such as nursing administration and supervision, rehabilitation nursing, psychiatric or geriatric nursing.

(2) The supervising nurse makes daily rounds to all nursing units performing such functions as visiting each patient, reviewing clinical records, medication cards, patient care plans and staff assignments, and to the greatest degree possible accompanying physicians when visiting patients.

(d) *Standard; Charge Nurse.*—There is at least one registered professional nurse or qualified licensed practical nurse who is a graduate of a State-approved school of practical nursing on duty at all times and in charge of the nursing activities during each tour of duty. The factors explaining the standard are as follows:

(1) A State-approved school of practical nursing is one whose standards of education meet those set by the appropriate State nurse licensing authority.

(2) Some State laws grant practical nurse li-

censure (nonwaivered) to certain individuals who have an educational background considered to be equivalent to graduation from a State-approved school of practical nursing. Such licensure determination is made by the appropriate State nurse licensing authority on the basis of evaluation of the individual's educational achievements, as well as on successful completion of the appropriate State licensing examination. Licensure under such conditions may be accepted as meeting the requirement of graduation from a State-approved school of practical nursing.

(3) It is desirable that the nurse in charge of each tour of duty be trained or experienced in areas such as nursing administration and supervision, rehabilitation nursing, psychiatric or geriatric nursing.

(4) The charge nurse has the ability to recognize significant changes in the condition of patients and to take necessary action.

(5) The charge nurse is responsible for the total nursing care of patients during her tour of duty.

(e) *Standard; 24-Hour Nursing Service.*—There is 24-hour nursing service with a sufficient number of nursing personnel on duty at all times to meet the total needs of patients. The factors explaining the standard are as follows:

(1) Nursing personnel include registered professional nurses, licensed practical nurses, aides and orderlies.

(2) The amount of nursing time available for patient care is exclusive of nonnursing duties.

(3) Sufficient nursing time is available to assure that each patient:

(i) Receives treatments, medications and diet as prescribed;

(ii) Receives proper care to prevent decubiti and is kept comfortable, clean, and well-groomed;

(iii) Is protected from accident and injury by the adoption of indicated safety measures;

(iv) Is treated with kindness and respect.

(4) Licensed practical nurses, nurses' aides, and orderlies are assigned duties consistent with their training and experience.

(f) *Standard; Restorative Nursing Care.*—There is an active program of restorative nursing care directed toward assisting each patient to achieve and maintain his highest level of self care and independence. The factors explaining the standard are as follows:

(1) Restorative nursing care initiated in the hos-

pital is continued immediately upon admission to the extended care facility.

(2) Nursing personnel are taught restorative nursing measures and practice them in their daily care of patients. These measures include:

(i) Maintaining good body alignment and proper positioning of bedfast patients;

(ii) Encouraging and assisting bedfast patients to change positions at least every 2 hours day and night to stimulate circulation, and prevent decubiti and deformities;

(iii) Making every effort to keep patients active and out of bed for reasonable periods of time, except when contraindicated by physicians' orders, and encouraging patients to achieve independence in activities of daily living by teaching self care, transfer and ambulation activities;

(iv) Assisting patients to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests if necessary;

(v) Assisting patients to carry out prescribed physical therapy exercises between visits of the physical therapist.

(3) Consultation and instruction in restorative nursing available from State or local agencies are utilized.

(g) *Standard; Dietary Supervision.*—Nursing personnel are aware of the dietary needs and food and fluid intake of patients. The factors explaining the standard are as follows:

(1) Nursing personnel observe that patients are served diets as prescribed.

(2) Patients needing help in eating are assigned promptly upon receipt of meals.

(3) Adaptive self-help devices are provided to contribute to the patient's independence in eating.

(4) Food and fluid intake of patients is observed and deviations from normal are reported to the charge nurse. Persistent unresolved problems are reported to the physician.

(h) *Standard; Nursing Care Plan.*—There is a written nursing care plan for each patient based on the nature of illness, treatment prescribed, long- and short-term goals and other pertinent information. The factors explaining the standard are as follows:

(1) The nursing care plan is a personalized, daily plan for individual patients. It indicates what nursing care is needed, how it can best be accomplished for each patient, how the patient likes things done, what methods and approaches are most suc-

successful, and what modifications are necessary to insure best results.

(2) Nursing care plans are available for use by all nursing personnel.

(3) Nursing care plans are reviewed and revised as needed.

(4) Relevant nursing information from the nursing care plan is included with other medical information when patients are transferred.

(i) *Standard; Inservice Educational Program.*—There is a continuing inservice educational program in effect for all nursing personnel in addition to a thorough job orientation for new personnel. Skill training for nonprofessional nursing personnel begins during the orientation period. The factors explaining the standard are as follows:

(1) Planned inservice programs are conducted at regular intervals for all nursing personnel.

(2) All patient care personnel are instructed and supervised in the care of emotionally disturbed and confused patients, and are helped to understand the social aspects of patient care.

(3) Skill training includes demonstration, practice, and supervision of simple nursing procedures applicable in the individual facility. It also includes simple restorative nursing procedures.

(4) Orientation of new personnel includes a review of the procedures to be followed in emergencies.

(5) Opportunities are provided for nursing personnel to attend training courses in restorative nursing and other educational programs related to the care of long-term patients.

405.1125 Condition of Participation—Dietary Services.—The dietary service is directed by a qualified individual and meets the daily dietary needs of patients. An extended care facility which has a contract with an outside food management company may be found to meet this condition of participation provided the company has a dietitian who serves, as required by the scope and complexity of the service, on a full-time, part-time or consultant basis to the extended care facility, and provided the company maintains standards as listed herein and provides for continuing liaison with the medical and nursing staff of the extended care facility for recommendations on dietetic policies affecting patient care.

(a) *Standard; Dietary Supervision.*—A person designated by the administrator is responsible for the total food service of the facility. If this person

is not a professional dietitian, regularly scheduled consultation from a professional dietitian or other person with suitable training is obtained. The factors explaining the standard are as follows:

(1) A professional dietitian meets the American Dietetic Association's qualification standards.

(2) Other persons with suitable training are graduates of baccalaureate degree programs with major studies in food and nutrition.

(3) The person in charge of the dietary service participates in regular conferences with the administrator and other supervisors of patient services.

(4) This person makes recommendations concerning the quantity, quality and variety of food purchased.

(5) This person is responsible for the orientation, training and supervision of food service employees, and participates in their selection and in the formulation of pertinent personnel policies.

(6) Consultation obtained from self-employed dietitians or dietitians employed in voluntary or official agencies is acceptable if provided on a frequent and regularly scheduled basis.

(b) *Standard; Adequacy of Diet Staff.*—A sufficient number of food service personnel are employed and their working hours are scheduled to meet the dietary needs of the patients. The factors explaining the standard are as follows:

(1) There are food service employees on duty over a period of 12 or more hours.

(2) Food service employees are trained to perform assigned duties and participate in selected inservice education programs.

(3) In the event food service employees are assigned duties outside the dietary department, these duties do not interfere with the sanitation, safety, or time required for dietary work assignments.

(4) Work assignments and duty schedules are posted.

(c) *Standards; Hygiene of Diet Staff.*—Food service personnel are in good health and practice hygienic food handling techniques. The factors explaining the standards are as follows:

(1) Food service personnel wear clean washable garments, hairnets, or clean caps, and keep their hands and fingernails clean at all times.

(2) Routine health examinations at least meet local, State, or Federal codes for food service personnel. Where food handlers' permits are required, they are current.

(3) Personnel having symptoms of communicable diseases or open infected wounds are not permitted to work.

(d) *Standard; Adequacy of Diet.*—The food and nutritional needs of patients are met in accordance with physicians' orders, and, to the extent medically possible, meet the dietary allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex and activity. A daily food guide for adults may be based on the following allowances:

(1) Milk: Two or more cups.

(2) Meat group: Two or more servings of beef, veal, pork, lamb, poultry, fish, eggs. Occasionally dry beans, nuts, or dry peas may be served as alternates.

(3) Vegetable and fruit group, four or more servings: A citrus fruit or other fruit and vegetable important for Vitamin C; a dark green or deep yellow vegetable for Vitamin A, at least every other day; other fruits and vegetables including potatoes.

(4) Bread and cereal group: Four or more servings of whole grain, enriched or restored.

(5) Other foods to round out meals and snacks, to satisfy individual appetites and provide additional calories.

(e) *Standard; Therapeutic Diets.*—Therapeutic diets are prepared and served as prescribed by the attending physician. The factors explaining the standard are as follows:

(1) Therapeutic diet orders are planned, prepared, and served with supervision or consultation from a qualified dietitian.

(2) A current diet manual recommended by the State licensure agency is readily available to food service personnel and supervisors of nursing service.

(3) Persons responsible for therapeutic diets have sufficient knowledge of food values to make appropriate substitutions when necessary.

(f) *Standard; Quality of Food.*—At least three meals or their equivalent are served daily, at regular times, with not more than a 14-hour span between a substantial evening meal and breakfast. Between-meal or bedtime snacks of nourishing quality are offered. If the "four or five meal a day" plan is in effect, meals and snacks provide nutritional value equivalent to the daily food guide previously described.

(g) *Standard; Planning of Menus.*—Menus are

planned in advance and food sufficient to meet the nutrition needs of patients is prepared as planned for each meal. When changes in the menu are necessary, substitutions provide equal nutritive value. The factors explaining the standard are as follows:

(1) Menus are written at least 1 week in advance. The current week's menu is in one or more accessible places in the dietary department for easy use by workers purchasing, preparing, and serving foods.

(2) Menus provide a sufficient variety of foods served in adequate amounts at each meal. Menus are different for the same days of each week and are adjusted for seasonal changes.

(3) Records of menus as served are filed and maintained for 30 days.

(4) Supplies of staple foods for a minimum of a 1-week period and of perishable foods for a minimum of a 2-day period are maintained on the premises.

(5) Records of food purchased for preparation are on file.

(h) *Standard; Preparation of Food.*—Foods are prepared by methods that conserve nutritive value, flavor, and appearance, and are attractively served at the proper temperatures and in a form to meet individual needs. The factors explaining the standard are as follows:

(1) A file of tested recipes, adjusted to appropriate yield, is maintained.

(2) Food is cut, chopped or ground to meet individual needs.

(3) If a patient refuses food served, substitutes are offered.

(4) Effective equipment is provided and procedures established to maintain food at proper temperature during serving.

(5) Table service is provided for all who can and will eat at a table including wheelchair patients.

(6) Trays provided bedfast patients rest on firm supports such as overbed tables. Sturdy tray stands of proper height are provided patients able to be out of bed.

(i) *Standard; Maintenance of Sanitary Conditions.*—Sanitary conditions are maintained in the storage, preparation and distribution of food. The factors explaining the standard are as follows:

(1) Effective procedures for cleaning all equipment and work areas are followed consistently.

(2) Dishwashing procedures and techniques are well developed, understood and carried out in compliance with the State and local health codes.

(3) Written reports of inspections by State or local health authorities are on file at the facility with notation made of action taken by the facility to comply with any recommendations.

(4) Waste which is not disposed of by mechanical means is kept in leak-proof nonabsorbent containers with close-fitting covers and is disposed of daily in a manner that will prevent transmission of disease, a nuisance, a breeding place for flies, or a feeding place for rodents. Containers are thoroughly cleaned inside and out each time emptied.

(5) Dry or staple food items are stored off the floor in a ventilated room not subject to sewage or waste water backflow, or contamination by condensation, leakage, rodents, or vermin.

(6) Handwashing facilities including hot and cold water, soap, and individual towels, preferably paper towels, are provided in kitchen areas.

(Par. (d) (3) amended 12-18-68.)

405.1126 Condition of Participation—Restorative Services.—Restorative services are provided upon written order of the physician.

(a) *Standard; Medical Direction.*—Restorative services are provided only upon written order by the physician, who indicates anticipated goals and is responsible for general medical direction of such services as part of the total care of the patient. The physician prescribes specific modalities to be used and frequency of physical and occupational therapy services.

(b) *Standard; Maintenance of Patient's Functions.*—At a minimum, restorative nursing care designed to maintain function or improve the patient's ability to carry out the activities of daily living is provided by the extended care facility. (See § 405.1124(f).)

(c) *Standard; Therapy Services.*—If restorative services beyond restorative nursing care are offered, whether directly or through cooperative arrangements with appropriate agencies such as hospitals, rehabilitation centers, State or local health departments, or independently practicing therapists, these services are given or supervised by therapists meeting the qualification set out below. When supervision is less than full time it is provided on a planned basis and is frequent enough, in relation to the staff therapist's training and experience to assure sufficient review of individual treatment plans and progress. The factors explaining the standard are as follows:

(1) Physical therapy is given or supervised by a therapist who meets one of the following requirements:

(i) He has graduated from a physical therapy curriculum approved by—

(A) The American Physical Therapy Association; or

(B) The Council on Medical Education and Hospitals of the American Medical Association; or

(C) The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or

(ii) Prior to January 1, 1966—

(A) Has been admitted to membership by the American Physical Therapy Association; or

(B) Has been admitted to registration by the American Registry of Physical Therapists; or

(C) Has graduated from a physical therapy curriculum in a four year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or

(iii) If trained outside the United States—

(A) Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

(B) Is a member of a member organization of the World Confederation for Physical Therapy; and

(C) Has completed one year's experience under the supervision of an active member of the American Physical Therapy Association; and

(D) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(2) Physical therapy includes such services as:

(i) Assisting the physician in his evaluation of patients by applying muscle, nerve, joint, and functional ability tests;

(ii) Treating patients to relieve pain, develop or restore function, and maintain maximum performance, using physical means such as exercise, massage, heat, water, light, and electricity.

(3) Speech therapy is given or supervised by a therapist who meets one of the following requirements:

(i) Has been granted a Certificate of Clinical Competence in the appropriate area (Speech Pathology or Audiology) by the American Speech and Hearing Association; or

(ii) Meets the equivalent educational requirements and work experience necessary for such certificate; or

(iii) Has completed the academic and practicum requirements for certification and is in the process of accumulating the necessary supervised work experience required for certification; or

(iv) Until January 1, 1970, has a Basic Certificate or provisional basic certification and is in the process of acquiring 4 years of sponsored professional experience; or

(v) Had a Basic Certificate or sponsor privilege as of December 31, 1964, cannot complete 4 years of sponsored professional experience before January 1, 1970, but passes a special examination given by the American Speech and Hearing Association during 1969.

(4) Speech therapy is service in speech, pathology or audiology, and may include:

(i) Cooperation in the evaluation of patients with speech, hearing, or language disorders;

(ii) Determination and recommendation of appropriate speech and hearing services;

(iii) Provision of necessary rehabilitative services for patients with speech, hearing, and language disabilities.

(5) Occupational therapy is given or supervised by a therapist who is registered by the American Occupational Therapy Association or is a graduate of a program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and is in the process of accumulating supervised clinical experience required for registration.

(6) Occupational therapy includes duties such as:

(i) Assisting the physician in his evaluation of the patient's level of function by applying diagnostic and prognostic tests;

(ii) Guiding the patient in his use of therapeutic creative and self-care activities for improving function.

(7) Other personnel providing restorative services are specially trained and work under professional supervision in accordance with accepted professional practices. For example, an occupational therapy assistant has successfully completed a training course approved by the American Occupational Therapy Association, is certified by that body as a certified occupational therapy assistant, and

receives supervision from a qualified occupational therapist.

(8) In a facility with an organized rehabilitation service using a multidisciplinary team approach to all the needs of the patient, and where all therapists' services are administered under the direct supervision of a physician qualified in physical medicine who will determine the goals and limits of the therapists' work, and prescribe modalities and frequency of therapy, persons with qualifications other than those described in subparagraphs (1), (3), and (5) of this paragraph could be assigned duties appropriate to their training and experience.

(9) Therapists collaborate with the facility's medical and nursing staff in developing the patient's total plan of care.

(10) Therapists participate in the facility's inservice education programs.

(d) *Standard; Ambulation and Therapeutic Equipment.*—Commonly used ambulation and therapeutic equipment necessary for services offered is available for use in the facility. The factors explaining the standard are as follows:

(1) Recommended ambulation equipment includes such items as parallel bars, hand rails, wheel chairs, walkers, walkerettes, crutches and canes.

(2) The therapists advise the administrator concerning the purchase, rental, storage, and maintenance of equipment and supplies.

405.1127 Condition of Participation—Pharmaceutical Services.—Whether drugs are generally procured from community or institutional pharmacists or stocked by the facility, the extended care facility has methods and procedures for its pharmaceutical services that are in accord with accepted professional practices.

(a) *Standard; Procedures for Administration of Pharmaceutical Services.*—The extended care facility provides appropriate methods and procedures for the obtaining, dispensing and administering of drugs and biologicals, developed with the advice of a staff pharmacist, a consultant pharmacist, or a pharmaceutical advisory committee which includes one or more licensed pharmacists. The factors explaining the standard are as follows:

(1) If the extended care facility has a pharmacy department, a licensed pharmacist is employed to administer the pharmacy department.

(2) If the facility does not have a pharmacy department, it has provision for promptly and con-

veniently obtaining prescribed drugs and biologicals from community or institutional pharmacists.

(3) If the facility does not have a pharmacy department, but does maintain a supply of drugs:

(i) The consultant pharmacist is responsible for the control of all bulk drugs and maintains records of their receipt and disposition.

(ii) The consultant pharmacist dispenses drugs from the drug supply, properly labels them and makes them available to appropriate licensed nursing personnel. Wherever possible, the pharmacist in dispensing drugs works from the prescriber's original order or a direct copy.

(iii) Provision is made for emergency withdrawal of medications from the drug supply.

(4) An emergency medication kit approved by the facility's group of professional personnel is kept readily available.

(5) The extended care facility has written policies covering pharmaceutical services which are developed with the advice of a group of professional personnel and which are reviewed at least annually. Pharmacy policies and procedures are preferably developed with the advice of a subgroup of physicians and pharmacists serving as a pharmacy and therapeutics committee.

(b) *Standard; Conformance With Physicians' Orders.*—All medications administered to patients are ordered in writing by the patient's physician. Oral orders are given only to a licensed nurse, immediately reduced to writing, signed by the nurse and countersigned by the physician within 48 hours. Medications not specifically limited as to time or number of doses, when ordered, are automatically stopped in accordance with written policy approved by the physician or physicians responsible for advising the facility on its medical administrative policies. The factors explaining the standard are as follows:

(1) The charge nurse and the prescribing physician together review monthly each patient's medications.

(2) The patient's attending physician is notified of stop order policies and contacted promptly for renewal of such orders so that continuity of the patient's therapeutic regimen is not interrupted.

(3) Medications are released to patients on discharge only on the written authorization of the physician.

(c) *Standard; Administration of Medications.*—All medications are administered by licensed med-

ical or nursing personnel in accordance with the Medical and Nurse Practice Acts of each State. Each dose administered is properly recorded in the clinical record. The factors explaining the standard are as follows:

(1) The nursing station has readily available items necessary for the proper administration of medication.

(2) In administering medications, medication cards or other State approved systems are used and checked against the physician's orders.

(3) Medications prescribed for one patient are not administered to any other patient.

(4) Self-administration of medications by patients is not permitted except for emergency drugs on special order of the patient's physician or in a predischarge program under the supervision of a licensed nurse.

(5) Medication errors and drug reactions are immediately reported to the patient's physician and an entry thereof made in the patient's clinical record as well as on an incident report.

(6) Up-to-date medication reference texts and sources of information are provided, such as the American Hospital Formulary Service of the American Society of Hospital Pharmacists or other suitable references.

(d) *Standard; Labeling and Storing Medications.*—Patients' medications are properly labeled and stored in a locked cabinet at the nurses' station. The factors explaining the standard are as follows:

(1) The label of each patient's individual medication container clearly indicates the patient's full name, physician's name, prescription number, name and strength of drug, date of issue, expiration date of all time-dated drugs, and name and address, and telephone number of pharmacy issuing the drug. It is advisable that the manufacturer's name and the lot or control number of the medication also appear on the label.

(2) Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacist or pharmacy for relabeling or disposal. Containers having no labels are destroyed in accordance with State and Federal laws.

(3) The medications of each patient are kept and stored in their originally received containers and transferring between containers is forbidden.

(4) Separately locked, securely fastened boxes (or drawers) within the medicine cabinet are provided for storage of narcotics, barbiturates, am-

phetamines and other dangerous drugs subject to the Drug Abuse Control Amendments of 1965.

(5) Cabinets are well lighted and of sufficient size to permit storage without crowding.

(6) Medications requiring refrigeration are kept in a separate, locked box within a refrigerator at or near the nursing station.

(7) Poisons and medications for "external use only" are kept in a locked cabinet and separate from other medications.

(8) Medications no longer in use are disposed of or destroyed in accordance with Federal and State laws and regulations.

(9) Medications having an expiration date are removed from usage and properly disposed of after such date.

(e) *Standard; Control of Narcotics, etc.*—The extended care facility complies with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics, those drugs subject to the Drug Abuse Control Amendments of 1965, and other legend drugs. The factor explaining the standard is as follows: A narcotic record is maintained which lists on separate sheets for each type and strength of narcotic the following information: date, time administered, name of patient, dose, physician's name, signature of person administering dose, and balance.

405.1128 Condition of Participation—Diagnostic Services.—The extended care facility has provision for obtaining required clinical laboratory, X-ray and other diagnostic services.

(a) *Standard; provisions for diagnostic services:* The extended care facility has provision for promptly and conveniently obtaining required clinical laboratory, X-ray and other diagnostic services. Such services may be obtained from a physician's office, a laboratory which is part of a hospital approved for participation in the Health Insurance for the Aged program or a laboratory which is approved to provide these services as an independent laboratory under the Supplementary Medical Insurance for the Aged program. If the facility provides its own diagnostic services, these meet the applicable conditions established for certification of hospitals that are contained in §§ 405.1028 and 405.1029.

(b) The factors explaining the standard are as follows:

(1) All diagnostic services are provided only on the request of a physician.

(2) The physician is notified promptly of the test results.

(3) Arrangements are made for the transportation of patients, if necessary to and from the source of service.

(4) Simple tests, such as those customarily done by nursing personnel for diabetic patients, may be done in the facility.

(5) All reports are included in the clinical record.

405.1129 Condition of Participation—Dental Services.—The extended care facility assists patients to obtain regular and emergency dental care. However, the services of dentists to individual patients are not included as a benefit in the basic hospital insurance program, and only certain oral surgery is included in the supplemental medical insurance program.

(a) *Standard; provision for dental care:* Patients are assisted to obtain regular and emergency dental care.

(b) The factors explaining the standard are as follows:

(1) An advisory dentist provides consultation, participates in in-service education, recommends policies concerning oral hygiene, and is available in case of emergency.

(2) The extended care facility, when necessary, arranges for the patient to be transported to the dentist's office.

(3) Nursing personnel assist the patient to carry out the dentist's recommendations.

405.1130 Condition of Participation—Social Services.—Services are provided to meet the medically related social needs of patients.

(a) *Standard; Provision for Medically Related Social Needs.*—The medically related social needs of the patient are identified, and services provided to meet them, in admission of the patient, during his treatment and care in the facility, and in planning for his discharge. The factors explaining the standard are as follows:

(1) As a part of the process of evaluating a patient's need for services in an extended care facility and whether the facility can offer appropriate care, emotional and social factors are considered in relation to medical and nursing requirements.

(2) As soon as possible after admission, there is evaluation, based on medical, nursing, and social factors, of the probable duration of the patient's

need for care and a plan is formulated and recorded for providing such care.

(3) Where there are indications that financial help will be needed arrangements are made promptly for referral to an appropriate agency.

(4) Social and emotional factors related to the patient's illness, to his response to treatment, and to his adjustment to care in the facility are recognized and appropriate action is taken when necessary to obtain casework services to assist in resolving problems in these areas.

(5) Knowledge of the patient's home situation, financial resources, community resources available to assist him, and pertinent information related to his medical and nursing requirements are used in making decisions regarding his discharge for the facility.

(b) Standard; Staff Members Responsible for Social Services.—There is a designated member of the staff of the facility who will take responsibility, when medically related social problems are recognized, for action necessary to solve them. The factors explaining the standard are as follows:

(1) There is a full-time or part-time social worker employed by the facility, or there is a person on the staff who is suited by training and/or experience in related fields to find community resources to deal with the social problems.

(2) The staff member responsible for this area of service has information promptly available on health and welfare resources in the community.

(3) If the facility does not have a qualified social worker on its staff, there is an effective arrangement with a public or private agency, which may include the local welfare department, to provide social service consultation.

(4) A qualified social worker is a graduate of a school of social work accredited by the Council on Social Work Education.

(c) Standard; Social Services Training of Staff.—There is provision for orientation and in-service training of staff directed toward understanding emotional problems and social needs of sick and infirm aged persons, and recognition of social problems of patients and the means of taking appropriate action in relation to them. Either a qualified social worker on the staff, or one from outside the facility, participates in training programs, case conferences, and arrangements for staff orientation to community services and patient needs.

(d) Standard; Confidentiality of Social Data.—Pertinent social data, and information about per-

sonal and family problems related to the patient's illness and care, are made available only to the attending physician, appropriate members of the nursing staff, and other key personnel who are directly involved in the patient's care, or to recognized health or welfare agencies. There are appropriate policies and procedures for assuring the confidentiality of such information. The factors explaining the standard are as follows:

(1) The staff member responsible for social services participates in clinical staff conferences and/or confers with the attending physician prior to admission of the patient, at intervals during the patient's stay in the facility, and prior to discharge of the patient, and there is evidence in the record of such conferences.

(2) The staff member and nurses responsible for the patient's care confer frequently and there is evidence of effective working relationships between them.

(3) Records of pertinent social information, and of action taken to meet social needs, are maintained for each patient; signed social service summaries are entered promptly in the patient's clinical record for the benefit of all staff involved in the care of the patient.

405.1131 Condition of Participation—Patient Activities.—Activities suited to the needs and interests of patients are provided as an important adjunct to the active treatment program and to encourage restoration to self-care and resumption of normal activities.

(a) Standard: provision for patient activity: Provision is made for purposeful activities which are suited to the needs and interests of patients.

(b) The factors explaining the standard are as follows:

(1) An individual is designated as being in charge of patient activities. This individual has experience and/or training in directing group activity, or has available consultation from a qualified recreational therapist or group activity leader.

(2) The activity leader uses, to the fullest possible extent, community, social and recreational opportunities.

(3) Patients are encouraged, but not forced, to participate in such activities. Suitable activities are provided for patients unable to leave their room.

(4) Patients who are able and who wish to do so are assisted to attend religious services.

(5) Patient's requests to see their clergymen are

honored and space is provided for privacy during visits.

(6) Visiting hours are flexible and posted to permit and encourage visiting by friends and relatives.

(7) The facility makes available a variety of supplies and equipment adequate to satisfy the individual interests of patients. Examples of such supplies and equipment are: Books and magazines, daily newspapers, games, stationery, radio and television, and the like.

405.1132 Condition of Participation—Clinical Records.—A clinical record is maintained for each patient admitted, in accordance with accepted professional principles.

(a) *Standard; Maintenance of Clinical Record.*—The extended care facility maintains a separate clinical record for each patient admitted with all entries kept current, dated, and signed. The record includes:

(1) Identification and summary sheet(s) including patient's name, social security number, marital status, age, sex, home address, and religion; names, addresses, and telephone numbers of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnosis; final diagnosis, condition on discharge, and disposition, and any other information needed to meet State requirements;

(2) Initial medical evaluation including medical history, physical examination, diagnosis, and estimation of restoration potential;

(3) Authentication of hospital diagnoses, in the form of a hospital summary discharge sheet, or a report from the physician who attended the patient in the hospital, or a transfer form used under a transfer agreement;

(4) Physician's orders, including all medications, treatments, diet, restorative and special medical procedures required for the safety and well-being of the patient;

(5) Physician's progress notes describing significant changes in the patient's condition, written at the time of each visit;

(6) Nurse's notes containing observations made by the nursing personnel;

(7) Medication and treatment record including all medications, treatments, and special procedures performed for the safety and well-being of the patient;

(8) Laboratory and X-ray reports;

(9) Consultation reports;

(10) Dental reports;

(11) Social service notes;

(12) Patient care referral reports.

(b) *Standard; Retention of Records.*—All clinical records of discharged patients are completed promptly and are filed and retained in accordance with State law or for 5 years in the absence of a State statute. The factors explaining the standard are as follows:

(1) The extended care facility has policies providing for the retention and safekeeping of patients' clinical records by the governing body for the required period of time in the event that the extended care facility discontinues operation.

(2) If the patient is transferred to another health care facility, a copy of the patient's clinical record or an abstract thereof accompanies the patient.

(c) *Standard; Confidentiality of Records.*—All information contained in the clinical records is treated as confidential and is disclosed only to authorized persons.

(d) *Standard; Staff Responsibility for Records.*—If the extended care facility does not have a full or part-time medical record librarian, an employee of the facility is assigned the responsibility for assuring that records are maintained, completed and preserved. The designated individual is trained by, and receives, regular consultation from a person skilled in record maintenance and preservation.

405.1133 Condition of Participation—Transfer Agreement.—The extended care facility has in effect a transfer agreement (meeting the requirements of section 1861(1) of the Social Security Act) with one or more hospitals which have entered into agreements with the Secretary to participate in the program. (See paragraph (e) of this section where facility attempted to enter into a transfer agreement.)

(a) *Standard; Patient Transfer.*—The transfer agreement provides reasonable assurance that transfer of patients will be effected between the hospital and the extended care facility whenever such transfer is medically appropriate as determined by the attending physician. The factors explaining the standard are as follows:

(1) The agreement is with a hospital close enough to the facility to make the transfer of patients feasible.

(2) The transfer agreement facilitates continuity

of patient care and expedites appropriate care for the patient.

(3) The agreement may be made on a one-to-one basis or on a community wide basis. The latter arrangement could provide for a master agreement to be signed by each hospital and extended care facility.

(4) When the transfer agreement is on a community wide basis it reflects the mutual planning and agreement of hospitals, extended care facilities and other related agencies.

(5) The institutions provide to each other information about their resources sufficient to determine whether the care needed by a patient is available.

(6) Where the transfer agreement specifies restrictions with respect to the types of services available in the hospital or the facility and/or the types of patients or health conditions that will not be accepted by the hospital or the facility, or includes any other criteria relating to the transfer of patients (such as priorities for persons on waiting lists), such restrictions or criteria are the same as those applied by the hospital or facility to all other potential inpatients of the hospital or facility.

(7) When a transfer agreement has been in effect over a period of time, a sufficient number of patient transfers between the two institutions have occurred to indicate that the transfer agreement is effective.

(b) Standard; Interchanges of Information.—The transfer agreement provides reasonable assurance that there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions. The factors explaining the standard are as follows:

(1) The agreement establishes responsibility for the prompt exchange of patient information to enable each institution to determine whether it can adequately care for the patient and to assure continuity of patient care.

(2) Medical information transferred includes current medical findings, diagnosis, rehabilitation potential, a brief summary of the course of treatment followed in the hospital or extended care facility, nursing and dietary information useful in the care of the patient, ambulation status, and pertinent administrative and social information.

(3) The agreement provides for the transfer of personal effects, particularly money and valuables, and for the transfer of information related to these items.

(c) Standard; Execution of Agreement.—The transfer agreement is in writing and is signed by individuals authorized to execute such agreement on behalf of the institutions, or, in case the two institutions are under common control, there is a written policy or order signed by the person or body which controls them. The factors explaining the standard are as follows:

(1) When the hospital and extended care facility are not under common control, the terms of the transfer agreement are established jointly by both institutions.

(2) Each institution participating in the agreement maintains a copy of the agreement.

(d) Standard; Specification of Responsibilities.—The transfer agreement specifies the responsibilities each institution assumes in the transfer of patients and information between the hospital and the extended care facility. The agreement establishes responsibility for notifying the other institution promptly of the impending transfer of a patient; arranging for appropriate and safe transportation; and arranging for the care of patients during transfer.

(e) Standard; Presumed Agreement Where Necessary for Provision of Services.—An extended care facility which does not have a transfer agreement in effect but which is found by the State agency conducting the survey (or, in the case of a State in which there is no such agency, by the Secretary) to have attempted in good faith to enter into a transfer agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and medical and other information, shall be considered to have such an agreement in effect if and for so long as it is also found that to do so is in the public interest and essential to assuring extended care services for patients in the community eligible for benefits. The factors explaining the standard are as follows:

(1) If there is only one hospital in the community, the extended care facility has attempted in good faith to enter into a transfer agreement with that hospital.

(2) If there are several hospitals in the community, the extended care facility has exhausted all reasonable possibilities of entering into a transfer agreement with these hospitals.

(3) The extended care facility has copies of letters, records of conferences, and other evidence to support its claim that it has attempted in good faith to enter into a transfer agreement.

(4) The State agency has found that hospitals in the community have, in fact, refused to enter into a transfer agreement with the extended care facility in question.

(5) The State agency has taken into consideration the availability of extended care facilities in the community and the expected need of such services for eligible beneficiaries under the law.

405.1134 Condition of Participation—Physical Environment.—The extended care facility is constructed, equipped, and maintained to insure the safety of patients and provides a functional, sanitary, and comfortable environment. The following standards are guidelines to help State agencies to evaluate existing structures which do not meet Hill-Burton construction regulations in effect at the time of the survey, and to evaluate in all facilities those aspects of the physical environment which are not covered by such Hill-Burton regulations. They are to be applied to existing construction with discretion and in light of community need for service.

(a) *Standard; Safety of Patients.*—The extended care facility is constructed, equipped, and maintained to insure the safety of patients. It is structurally sound and satisfies the following conditions:

(1) The facility complies with all applicable State and local codes governing construction.

(2) Fire resistance and flamespread ratings of construction, materials, and finishes comply with current State and local fire protection codes and ordinances.

(3) Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas considered to have special fire hazards including but not limited to boiler rooms, trash rooms, and nonfire resistant areas or buildings. In an extended care facility of two or more stories fire alarm systems providing complete coverage of the building are installed and inspected regularly. Fire extinguishers are conveniently located on each floor and in special hazard areas such as boiler rooms, kitchens, laundries, and storage rooms. Fire regulations are prominently posted and carefully observed.

(4) Doorways, passageways, and stairwells are wide enough for easy evacuation of patients and are kept free from obstruction at all times. Corridors are equipped with firmly secured handrails on each side. Stairwells, elevators, and all vertical shafts with openings have fire doors kept normally in closed position. Exit facilities comply with State and local codes and regulations.

(5) Unless the facility is of fire resistive construction, blind and nonambulatory or physically handicapped persons are not housed above the street level floor.

(6) Reports of periodic inspections of the structure by the fire control authority having jurisdiction in the area are on file in the facility.

(7) The building is maintained in good repair and kept free of hazards such as those created by any damaged or defective parts of the building.

(8) No occupancies or activities undesirable to the health and safety of patients are located in the building or buildings of the extended care facility.

(b) *Standard; Favorable Environment for Patients.*—The extended care facility is equipped and maintained to provide a functional, sanitary and comfortable environment. Its electrical and mechanical systems (including water supply and sewage disposal) are designed, constructed and maintained in accordance with recognized safety standards and comply with applicable State and local codes and regulations. The factors explaining the standard are as follows:

(1) Lighting levels in all areas of the facility are adequate and void of high brightness, glare, and reflecting surfaces that produce discomfort. Lighting levels are in accordance with recommendations of the Illuminating Engineering Society. The use of candles, kerosene oil lanterns, and other open flame methods of illumination is prohibited.

(2) An emergency electrical service, which may be battery operated if effective for 4 or more hours, covers lights at nursing stations, telephone switchboard, night lights, exit and corridor lights, boiler room, and the fire alarm system.

(3) The heating and air-conditioning systems are capable of maintaining adequate temperatures and providing freedom from drafts.

(4) An adequate supply of hot water for patient use is available at all times. Temperature of hot water at plumbing fixtures used by patients is automatically regulated by control valves and does not exceed 110° F. (110 degrees Fahrenheit).

(5) The facility is well-ventilated through the use of windows, mechanical ventilation, or a combination of both. Rooms and areas which do not have outside windows and which are used by patients or personnel are provided with functioning mechanical ventilation to change the air on a basis commensurate with the type of occupancy.

(6) All inside bathrooms and toilet rooms have forced ventilation to the outside.

(7) Laundry facilities (when applicable) are located in areas separate from patient units and are provided with the necessary washing, drying, and ironing equipment.

(c) *Standard; Elevators.*—Elevators are installed in the facility if patient bedrooms are located on floors above the street level. The factors explaining the standard are as follows:

(1) Installation of elevators and dumbwaiters complies with all applicable codes.

(2) Elevators are of sufficient size to accommodate a wheeled stretcher.

(d) *Standard; Nursing Unit.*—Each nursing unit has at least the following basic service areas: Nurses' station, medicine storage and preparation area, space for storage of linen, equipment and supplies, and a utility room. The factors explaining the standard are as follows:

(1) A nurses' call system registers calls at the nurses' station from each patient bed, patient toilet room, and each bathtub or shower.

(2) Equipment necessary for charting and recordkeeping is provided.

(3) The medication preparation area is well-illuminated and is provided with hot and cold running water.

(4) The utility room is located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment and supplies.

(5) Toilet and handwashing facilities are provided.

(e) *Standard; Patients' Bedrooms and Toilet Facilities.*—Patients' bedrooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. Each bedroom has or is conveniently located near adequate toilet and bathing facilities. Each bedroom has direct access to a corridor and outside exposure with the floor at or above grade level. The factors explaining the standard are as follows:

(1) Ordinarily rooms have no more than four beds with not less than 3 feet between beds.

(2) In addition to basic patient care equipment each patient unit has a nurses' call signal, an individual reading light, bedside cabinet, comfortable chair, and storage space for clothing and other possessions. In multiple bedrooms, each bed has flameproof cubicle curtains or their equivalent.

(3) It is desirable that each patient room have a lavatory with both hot and cold running water,

unless provided in adjacent toilet or bathroom facilities.

(4) On floors where wheelchair patients are located, there is at least one toilet room large enough to accommodate wheelchairs.

(5) Each bathtub or shower is in a separate room or compartment which is large enough to accommodate wheelchair and attendant.

(6) At least one water closet, enclosed in a separate room or stall, is provided for each eight beds.

(7) Substantially secured grab bars are installed in all water closet and bathing fixture compartments.

(8) Doors to patient bedrooms are never locked.

(f) *Standard; Facilities for Isolation.*—Provision is made for isolating infectious patients in well-ventilated single bedrooms having separate toilet and bathing facilities. Such facilities are also available to provide for the special care of patients who develop acute illnesses while in the facility and patients in terminal phases of illness.

(g) *Standard; Examination Rooms.*—A special room (or rooms) is provided for examinations, treatments, and other therapeutic procedures. The factors explaining the standard are as follows:

(1) This room is of sufficient size and is equipped with a treatment table, lavatory or sink with other than hand controls, instrument sterilizer, instrument table, and necessary instruments and supplies.

(2) If the facility provides physical therapy, areas are of sufficient size to accommodate necessary equipment and facilitate the movement of disabled patients. Lavatories and toilets designed for the use of wheelchair patients are provided in such areas.

(h) *Standard; Dayroom and Dining Area.*—The extended care facility provides one or more attractively furnished multipurpose areas of adequate size for patient dining, diversional and social activities. The factors explaining the standard are as follows:

(1) At least one dayroom or lounge, centrally located, is provided to accommodate the diversional and social activities of the patients. In addition, several smaller dayrooms, convenient to patient bedrooms, are desirable.

(2) Dining areas are large enough to accommodate all patients able to eat out of their rooms. These areas are well-lighted and well-ventilated.

(3) If a multipurpose room is used for dining and diversional and social activities, there is suf-

ficient space to accommodate all activities and prevent their interference with each other.

(i) *Standard; Kitchen or Dietary Area.*—The extended care facility has a kitchen or dietary area adequate to meet food service needs and arranged and equipped for the refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas comply with the local health or food handling codes. Food preparation space is arranged for the separation of functions and is located to permit efficient service to patients and is not used for nondietary functions.

405.1135 Condition of Participation—Housekeeping Services.—The extended care facility provides the housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment.

(a) *Standard; Housekeeping Services.*—The facility provides sufficient housekeeping and maintenance personnel to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. Nursing personnel are not assigned housekeeping duties. The factors explaining the standard are as follows:

(1) Housekeeping personnel, using accepted practices and procedures, keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and safety hazards.

(2) Floors are cleaned regularly. Polishes on floors provide a nonslip finish; throw or scatter rugs are not used except for nonslip entrance mats.

(3) Walls and ceilings are maintained free from cracks and falling plaster, and are cleaned and painted regularly.

(4) Deodorizers are not used to cover up odors caused by unsanitary conditions or poor housekeeping practices.

(5) Storage areas, attics, and cellars are kept safe and free from accumulations of extraneous materials such as refuse, discarded furniture, and old newspapers. Combustibles such as cleaning rags and compounds are kept in closed metal containers.

(6) The grounds are kept free from refuse and litter. Areas around buildings, sidewalks, gardens, and patios are kept clear of dense undergrowth.

(b) *Standard; Pest Control.*—The facility is maintained free from insects and rodents. The factors explaining the standard are as follows:

(1) A pest control program is in operation in

the facility. Pest control services are provided by maintenance personnel of the facility or by contract with a pest control company. Care is taken to use the least toxic and least flammable effective insecticides and rodenticides. These compounds are stored in nonpatient areas and in nonfood preparation and storage areas. Poisons are under lock.

(2) Windows and doors are appropriately screened during the insect breeding season.

(3) Harborages and entrances for insects and rodents are eliminated.

(4) Garbage and trash are stored in areas separate from those used for the preparation and storage of food and are removed from the premises in conformity with State and local practices. Containers are cleaned regularly.

(c) *Standard; Linen.*—The facility has available at all times a quantity of linen essential for the proper care and comfort of patients. Linens are handled, stored, and processed so as to control the spread of infection. The factors explaining the standard are as follows:

(1) The linen supply is at least three times the usual occupancy.

(2) Clean linen and clothing are stored in clear, dry, dust-free areas easily accessible to the nurses' station.

(3) Soiled linen is stored in separate well-ventilated areas, and is not permitted to accumulate in the facility. Soiled linen and clothing are stored separately in suitable bags or containers.

(4) Soiled linen is not sorted, laundered, rinsed, or stored in bathrooms, patient rooms, kitchens or food storage areas.

405.1136 Condition of Participation—Disaster Plan.—The extended care facility has a written procedure to be followed in case of fire or other disaster.

(a) *Standard; Disaster Plan.*—The facility has a written procedure to be followed in case of fire, explosion or other emergency. It specifies persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless patients, frequency of fire drills, and assignment of specific tasks and responsibilities to the personnel of each shift.

(b) The factors explaining the standard are as follows:

(1) The plan is developed with the assistance of qualified fire and safety experts.

(2) All personnel are trained to perform assigned tasks.

(3) Simulated drills testing the effectiveness of the plan are conducted on each shift at least three times a year.

(4) The plan is posted throughout the facility.

405.1137 Condition of Participation—

Utilization Review Plan.—(a) *Condition.*—The extended care facility has in effect a plan for utilization review which applies at least to the services furnished by the facility to individuals entitled to benefits under title XVIII of the Act, and meets all other requirements of section 1861(k) of the Social Security Act. An acceptable utilization review plan provides for: (1) The review on a sample or other basis, of admissions, duration of stays, and professional services furnished; and (2) review of each case of continuous extended duration.

(b) *General.*—(1) There are many types of plans which can fulfill the requirements of title XVIII of the Act. Extended care facilities wishing to establish their eligibility to participate will be required to submit a written description of their utilization review plan and a certification that it is currently in effect or that it will be in effect no later than the first day on which the extended care facility expects to become a participating provider of services. Ordinarily, this will constitute sufficient evidence to support a finding that the utilization review plan of the extended care facility is or is not in conformity with the statutory requirements.

(2) The review plan of an extended care facility should have as its overall objectives the maintenance of high quality patient care, more effective utilization of extended care services (through the mechanism of an educational approach involving study of patterns of care), the encouragement of appropriate utilization, and the assurance of continuity of care upon discharge (through, among other things, the accumulation of appropriate data on the availability of other facilities and services).

(3) The review of professional services furnished might include study of such conditions as overuse or underuse of services, proper use of consultation, and whether the required nursing and related care is initiated and carried out promptly. While review of lengths of stay for purposes of determining whether continued inpatient stay in the extended care facility is medically necessary, must be based on medical factors, the plan should take into account the need to assure that assistance is available to the physician in arranging for discharge planning.

(4) Costs incurred in connection with the implementation of the utilization review plan are includable in reasonable costs and are reimbursable to the extent that such costs relate to health insurance program beneficiaries.

(c) *Standard; Responsibility for Plan.*—The operation of the utilization review plan is a responsibility of the medical profession. The plan for reviewing utilization in the facility is developed with the advice of the facility's group of professional personnel referred to in § 405.1122 and has the approval of the facility's medical staff, if any, and the facility's governing body.

(d) *Standard; Statement of Plan.*—The extended care facility has a currently applicable, written description of its utilization review plan. Such description includes:

(1) The organization and composition of the committee(s) which will be responsible for the utilization review functions;

(2) Frequency of meetings;

(3) The type of records to be kept;

(4) The method to be used in selecting cases on a sample or other basis;

(5) The definition of what constitutes the period or periods of extended duration;

(6) The relationship of the utilization review plan to claims administration by a third party;

(7) Arrangements for committee reports and their dissemination;

(8) Responsibilities of the facility's administrative staff in support of utilization review.

(e) *Standard; Conduct of Review.*—(1) The utilization review function is conducted by one or a combination of the following (except that with respect to facilities lacking an organized medical staff, review is conducted only as in subdivision (ii) or (iii) of this subparagraph):

(i) By a staff committee of the facility, which is composed of two or more physicians, with or without the inclusion of other professional personnel; or

(ii) By a committee(s) or group(s) outside the facility composed as in subdivision (i) of this subparagraph which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality; or

(iii) Where a committee(s) or group(s) as described in subdivision (i) or (ii) of this subparagraph has not been established to carry out all the utilization review functions prescribed by the Act,

by a committee(s) or group(s) composed as in subdivision (i) of this subparagraph, and sponsored and organized in such manner as approved by the Secretary.

(2) The factors explaining the standard are as follows:

(i) The medical care appraisal and educational aspects of review on a sample or other basis, and the review of long-stay cases need not be done by the same committee or group.

(ii) In a facility with an organized medical staff, all of the review functions may be carried out in the facility by a committee of the whole or a medical care appraisal committee.

(iii) The committee(s) include at least one physician member who does not have a direct financial interest in the institution.

(iv) Under subparagraph (1)(iii) of this paragraph, any sponsorship of a utilization committee or group is ordinarily acceptable if it is composed as in subparagraph (1)(i) of this paragraph.

(f) *Standard; Basis for Review.*—(1) Reviews are made, on a simple or other basis, of admissions, duration of stays, and professional services (including drugs and biologicals) furnished, with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services. Such reviews emphasize identification and analysis of patterns of patient care in order to maintain consistent high quality. The review is accomplished by considering the data obtained by any one or any combination of the following:

(i) By use of services and facilities of external organizations which compile statistics, design profiles, and produce other comparative data; or

(ii) By cooperative endeavor with the fiscal intermediary or State agency; or

(iii) By studies of medical records of patients of the institution.

(2) The factors explaining the standard are as follows:

(i) Some review functions are carried out on a continuing basis.

(ii) Reviews include a sample of physician recertifications of medical necessity for extended care facility services, as made for purposes of the Health Insurance for the Aged program.

(g) *Standard; Extended Duration Cases.*—(1) Reviews are made of each beneficiary case of continuous extended duration. The definition of such

extended duration is reasonable and consonant with the intent of the benefit. The extended care facility's utilization review plan specifies the number of continuous days of stay in the extended care facility following which a review is made to determine whether further inpatient extended care services are medically necessary. The plan may specify a different number of days for different classes of cases.

(2) Reviews for such purpose are made no later than the seventh day following the last day of the period of extended duration specified in the plan. No physician has review responsibility for any case of continuous extended duration in which he was professionally involved.

(3) If physician members of the committee decide, after opportunity for consultation is given the attending physician by the committee, that further inpatient stay is not medically necessary, there is to be prompt notification (within 48 hours) in writing to the facility, the physician responsible for the patient's care, and the patient or his representative. Because there are significant divergencies in opinion among individual physicians with respect to evaluation of medical necessity for posthospital extended care services, the judgment of the attending physician in an extended stay case is given great weight, and is not rejected except under unusual circumstances.

(h) *Standard; Maintenance of Records of Review.*—Records are kept of the activities of the committee; and reports are regularly made by the committee to the executive committee of the medical staff (if any) or to the facilities, institutions, and organizations sponsoring the utilization review plan, and relevant information and recommendations are reported through usual channels to the entire medical staff and the governing body of the facility, and the sponsor of the plan. The factors explaining the standard are as follows:

(1) The extended care facility administration studies and acts upon Administrative recommendations made by the utilization review committee.

(2) A summary of the number and types of cases reviewed, and the findings, are part of the records of the committee and the participating facilities and institutions.

(3) Minutes of each committee meeting are maintained.

(4) Committee action in extended stay cases is recorded, with cases identified only by case number when possible.

(i) *Standard; Staff Cooperation With Review*

Committee.—The committee(s) having responsibility for utilization review functions have the support and assistance of the facility's administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, promoting the most efficient use of available health services and facilities, and in planning for the patient's continuity of care upon discharge. The factors explaining the standard are as follows:

(1) With respect to each of these activities, an individual or department is designated as being responsible for the particular service.

(2) In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for care following extended facility care is initiated as promptly as possible, either by the facility's staff, or by arrangement with other agencies. For this purpose, the facility makes available to the attending physician current information on resources available for continued noninstitutional or custodial care of patients and arranges for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.

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